Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY SUTIE 2200
HOUSTON TX 77027

Respondent Name

TEXAS MUNICIPAL LEAGUE
INTERGOVERNMENTAL RISK

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-07-5253-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. The carrier issued an underpayment of $105,090.14 and denied any additional reimbursement on the basis that payment issued was fair and reasonable."

Amount in Dispute: $81,139.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Self-insured has issued payment well in excess of the per diem reimbursement schedule. Self-insured would assert that its reimbursement is based upon a fair and reasonable reimbursement. Requestor has submitted no documentation to demonstrate that a higher reimbursement would be a fair and reasonable reimbursement."

Response Submitted by: Charles C. Finch, City of LaPorte, c/o Flahive, Ogden & Latson, 505 West 12th Street, Austin, TX 78701

On July 3, 2007, a supplemental response was submitted by Steven M. Tipton, which states "Requestor indicates it was not required to obtain preauthorization for this emergency admission. However, concurrent review for the extended stay was required and was not obtained".

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2006 through May 5, 2006	Outpatient Surgery	$81,139.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on April 17, 2007.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 601-Non-physician provider reimbursed @ 75%.
   - W1-Workers Compensation state fee schedule adj.
   - 62-Pre-certification/authorization absent or exceeded.
   - W11-Entitlement to benefits. Not finally adjudicated.
   - 940-Re-evaluation-no additional payment recommended.
   - B13-Payment for service may have been previously paid.
   - W4-No additional payment allowed after review.

Findings

1. The respondent denied reimbursement for lab and chemistry testing with EOB denial reason code "W11-Entitlement to benefits. Not finally adjudicated" on the initial EOB. The Division finds that on the reconsideration EOBs, the respondent did not maintain this denial reason upon reconsideration. A review of Division records does not support an entitlement issue exists; therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The requestor billed $186,230.00 for inpatient hospital surgical services rendered from April 16, 2006 through May 5, 2006. The respondent paid $105,090.14. The respondent denied reimbursement for dates of service April 18, 2006 through April 23, 2006 based upon "62-Pre-certification/authorization absent or exceeded."

   The requestor disagrees with the respondent and contends that additional payment is due because this admission was for emergency services for a trauma diagnoses.

   28 Texas Administrative Code §134.600(b)(1) effective March 14, 2004, states that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section only when the following situations occur:
   (A) an emergency, as defined in §133.1 of this title (relating to Definitions);
   (B) preauthorization of any health care listed in subsection (h) of this section that was approved prior to providing the health care;
   (C) concurrent review of any health care listed in subsection (i) of this section that was approved prior to providing the health care; or
   (D) when ordered by the commission."

   The respondent does not dispute that the initial treatment was for a medical emergency and did not require

preauthorization. The respondent states in the position summary that "…concurrent review for the extended stay was required and was not obtained."

28 Texas Administrative Code §134.600(i)(1) effective March 14, 2004, requires preauthorization for concurrent review for an extension of "inpatient length of stay."

The Division finds that the requestor did not obtain preauthorization approval for concurrent review for inpatient hospitalization in accordance with 28 Texas Administrative Code §134.600(i)(1); therefore, additional payment is not recommended.

3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 866.02. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "it is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. The carrier issued an underpayment of $105,090.14 and denied any additional reimbursement on the basis that payment issued was fair and reasonable."
   - The requestor does not discuss or explain how payment of $81,139.86 would result in a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under

Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.